Connecticut
Medicaid Managed Care Council

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MEETING SUMMARY

SEPTEMBER 15, 2000

Present: Senator Toni Harp (Chair), Rep. Vickie Nardello, Dr. Wilfred Reguero, Dr. Leonard Banco, David Parrella & James Gaito (DDS), Marie Roberto (DPH), Holly Miller Sullivan for Paul DeLio (DMHAS), Robert Gribbon (Comptroller Office), Dorian Long for Gary Blau (DCF), Bart Bracken, Jeffrey Walter, Ellen Andrews, Dr. Edward Kamens, Gracie Brown for Rev. Bonita Grubbs, Lisa Sementilli-Dann, Janice Perkins (PHS), Patrick Carolan (BeneCare).

Also present: Dr. Judith Krauss, Paula Armbruster, Sylvia Kelly (CHNCT), Deborah Hine (BCFP), Linda Scofield (Preferred One), James Linnane, Martha Okafor (DSS), Judy Bell (Qualidigm), Mariette McCourt (Council staff) .

Safety Net system: Institute of Medicine (IOM) Briefing

Dr. Judith Krauss, former Dean of the Yale School of Nursing, participated in the national IOM study of America's Health Care Safety Net System that assessed the impact of Medicaid managed care and changes in health care coverage on the future viability of Safety Net Providers. The 14-member committee conducted its work through literature research, workshops and public hearings, site visits and structured interviews. The health care safety net was defined as " those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid and other vulnerable patients". These providers maintain an "open door" service access policy, have a narrow patient mix (primarily Medicaid and the uninsured), have little or no ability to cost shift and provide wraparound services.

The study findings identified the strengths and challenges facing the safety net system and the vulnerable populations they serve, as best can be assessed in a point-in-time study within a dynamic health care environment:

- Most SNP are surviving and adapting to the new managed care environment; however may are "on the edge". Over 90 out of 350 MCOs have safety net roots.
- The fragile nature of the SNP makes the system vulnerable to changes. The rising number of uninsured, the impact of Medicaid managed care on a system that provides services not taken into account in the MC model, greater competition for a smaller number of Medicaid patients and the erosion and uncertainty of subsidies place added strain on the financial viability of the SNP system.
- The MC model offers the potential to improve health care for patients; however the turbulent market of rapid health plan turnover and cycling of patients on and off Medicaid may undermine this potential and adversely affect provider capacity.

- The organization and funding of the SNP system varies widely from community to community. The availability of care for the uninsured and other vulnerable populations increasingly depends on where they live. Communities with high demands for SNP services often have weak economic and social infrastructures.
- The status of the SNP system continues to change as does the health environment it is a part of, making it difficult to assess the impact of change on vulnerable populations. The present capacity for monitoring the effects of market and policy changes on the SNPs and their clients is inadequate.

Several key points were raised in the study:

- The evolution of Medicaid/SCHIP managed care requires the evolution of SNP.
- As more complex populations enter MC, SNPs must continue the development of capacity and infrastructure to provide care.
- FQHC based vs. hospital-based MCOs must sort out different internal incentives.
- Attention must be paid to the overall burdens and well-being of safety net providers and plans in the absence of a universal health care system.
- Return to Fee-for-Service Medicaid is no longer an option.

There were four crosscutting themes in the Committee recommendations:

- Give SNPs the tools to survive and compete in the new environment.
- Strengthen the local safety net capacity and future viability of SNPs by motivating SNPs and federal, state and local government agencies to develop integrated safety net systems.
- Link support for SNPs to their ability to effectively care for the uninsured and other vulnerable populations in their communities.
- Improve the quality and credibility of the data that policymakers and politicians rely on to make decisions related to SNPs.

The Council had the opportunity to discuss the report and current issues in CT related to the SNP system were raised after the presentation and throughout the meeting:

- Dean Krauss was asked how the Dept. of Health and Human Services has responded to the report's funding recommendations. Rep. Nardello commented that the Council, through the Public Health Subcommittee, had recommended a study of the SNP system under managed care; however funds were not allocated to do this. Dean Krauss stated that IOM will continue to track the status of the SNP system and she will share reports and possible funding resources with Rep. Nardello and DPH. Marie Roberto (DPH) stated that her department and the Yale University School of Nursing will continue to work together, as they have in the past, in looking at the Safety Net system. Uniformity of data collection is a serious issue and funds are needed to establish state-level data uniformity, using the data currently provided by FQHC's as the basis for data uniformity.

- Sen. Harp commented that the Greater Hartford VNA office, an urban SNP to Medicaid clients (MC and the dually eligible), is no longer taking Medicaid patients. The IOM report noted that some traditional Medicaid providers have stopped taking Medicaid clients because of reimbursement rates. Dean Krauss responded that the study committee did not look specifically at home care services but the report did indicate that certain providers found they were unable, economically, to continue to participate in Medicaid MC. Some provider's niches were too limited and they found they couldn't sustain themselves in a system that was based on the premise that competition was

good, that quality of care and cost control would be improved. These smaller SNP entities need to consider partnering with other groups in order to continue to provide valuable services that are irreplaceable iwithn the SN system.

- Sen. Harp requested DSS to comment on the State's view of the SNP system, in particular on the VNA issue. Mr. Parrella commented that the issue with the Hartford VNA reflects the economic realities created by federal changes of the Balanced Budget Act of 1997 that includes the upcoming Prospective Payment System (PPS) for hospital outpatient services that will lead to further reductions in reimbursement rates in Medicare. The economic impact on states of the Medicare changes on Medicaid is a pressing issue; providers will now look to states to make up the federal funding reductions.

  Marie Roberto (DPH) stated that the Department is monitoring the provision and continuity of services at the Hartford VNA during the transition. The Department is meeting with the VNA on 9/15/00 to discuss the impact of federal and state regulations on the service delivery issue.

  David Parrella noted that the CT Medicaid Managed Care program began with two SNP (FQHC) health plans of which one is still participating in HUSKY, and several hospital-based plans, none of which are now viable. The remaining FQHC plan remains a viable partner (DSS is working with CHNCT to reconcile an operational billing problem). While the SNP system issues are difficult, they are not insurmountable. However, the Department of Social Services budget realities and constraints make it difficult to expand or create new programs. The Department now has approximately a $78M deficiency for FY01 that began July 1, 2000. This deficiency is largely attributed to the growing Medicaid pharmacy expenditures that were not addressed in the last legislative session. Four years ago Medicaid prescription drug expenditures were $150M; last year the cost was $278M, almost double the cost 4 years ago. Thus issues like the VNA problem are difficult to solve in the face of the existing financial deficiencies that may well increase as the fiscal year progresses. Rep Nardello stated that the Council, in the past has identified problems within the HUSKY program that relate to SNP system and adequate funding to provide a reasonable level of care. In light of the Department's financial deficiencies and the State's spending cap, difficult decisions by the legislative and executive branches need to made if the State wishes to continue all the services within the safety net system.

  - Dr. Reguero stated that hospitals are concerned with the 1999 legislation that resulted in DMHAS withdrawing funding for ambulance transportation of patients to state alcohol/substance abuse facilities. The CT Hospital Association had worked with DMHAS but the issue has remained unresolved. Holly Miller Sullivan (DMHAS) stated that the Department is aware of the funding removal for transportation of uncompensated care clients (clients in SAGA have transportation funding) and DMHAS is looking for alternative funding sources. Senator Harp stated that the legislation did not remove the funds, rather the wording in the statute ("may") allowed DMHAS to look in the budget to find the transportation money. The legislature is willing to work with DMHAS to deal with this problem because available transportation within the SNP system is important.

Senator Harp thanked Dean Krauss for the presentation, commending her and the committee for its work. While the intent under managed care was not to harm the SNP system, we may not have been as successful as we had hoped. The outcome of the viability of the SNP under managed care requires continued attention and monitoring.

Benova Enrollment Report

Jessica Allen, Acting Regional Director of Benova, the State enrollment broker, reported on enrollment in both programs. The following summarizes the data presented:

HUSKY A & B Enrollment Jan.-September 2000

	Jan	Feb	March	April	May	June	July	Aug	Sept
Total A	229,229	230,856	231,766	233,327	234,101	234,006	229,995	230,739	230,6
<19YO (A)	171,968	173,339	174,269	175,475	176,385	176,636	173,087	174,176	173,9
Total B	4,666	4,827	5,060	5,221	5,577	5,761	6,155	6,450	6,71

HUSKY A & B Enrollment by Plan (9/1/00)

	Blue Care	CHNCT	PHS	Preferred One	Total
HUSKY A	88,745	39,242	78,534	24,099	230,620
HUSKY B	4,819	898	NA	1,001	6,718

HUSKY A & B Enrollment by Race

	Alaskan Eskimo	Asian	Black	Caucasian	Hispanic	Native American	Pacific Islander	Unknown	Tot
HUSKY A	1	3,578	65,736	81,714	79,174	353	64	NA	230
HUSKY B	2	149	655	4,367	838	25	2	680	6,

The Council questioned what happened in July 2000 and why was there a larger drop this year compared to the June-July 1999 decrease in enrollment? (*There was a 4% decrease in 1999 (834 enrollees) compared to a 17% decrease in 2000 (4011 enrollees). The difference in June 1999 enrollment from June 2000 was 2955, a 12% increase in overall HUSKY A enrollment in June 2000).* Mr Parrella replied that the largest loss of HUSKY A occurred in the F26 category (continuously enrolled children). The loss of CE children represents an administrative problem that involves:

- Lack of follow-up of families at the renewal time.
- Misapplication of eligibility criteria (i.e. applying asses limits when they do not apply in HUSKY A) on the regional level.
- Transitioning A's to the B program remains an administrative problem.

In an attempt to simplify the renewal process, Mr. Parrella stated the Department is thinking of sending a pre-printed HUSKY application (the client's previous application for HUSKY A),

similar to what is now done for HUSKY B at the renewal time. The Department has begun sending out renewal notices in advance of the end of the CE eligibility period and will address regional staff training to correct the administrative problems.

The Department is researching the reasons for the more significant drop-off of enrollees in July 2000. It may be that CT is now experiencing difficulties other states have had in the de-linking of welfare from Medicaid. At the time of welfare reform, the state implemented a two- year Medicaid extension for transitioning AFDC families, 12 month CE for children in HUSKY and 6 month adult CE. These administrative changes were made to defer the impact of the uncoupling of cash assistance and health coverage; however the shortcomings in the HUSKY eligibility processes are now coming to light. Dr. Ronald Preston, HCFA Deputy Regional administrator for the NE was present and commented that HCFA is just starting to deal with the loss of eligible enrollees at the redetermination time. This is national problem; CT has had better success in keeping eligible families in Title XIX compared to other states. The best resolution would be to allow enrollees to remain enrolled until the State determines they are no longer eligible, similar to private insurance programs. Federal rules do not allow this at this time.

Senator Harp commented that the Council has been talking about these issues for almost two years, has made recommendations to DSS for resolution of the problems and is frustrated that partial 'fixes' have not resolved the episodic losses of enrollees from the program and the modest HUSKY B enrolment numbers. **The Department was asked to report back to the Council in October, identifying the system issues, possible remedies that DSS will implement and the time frame for that implementation.**

Rep. Vickie Nardello reminded the Council that eligible HUSKY consumers who remain uninsured or lose HUSKY coverage continue to receive care most often from safety net providers. Their uninsured status creates a financial burden on the SNP system. Rep. Nardello stated that the Council has, in the past, recommended the department integrate HUSKY outreach for enrollment and renewal with the school system. **Rep. Nardello requested DSS report in October what has been achieved in HUSKY outreach in the schools**.

Department of Social Services Report
Program Update

- The Department is working with Preferred One on the possible acquisition of P-1 by another health plan. It is expected a resolution of P-1's transition, either to another MCO or termination of participation in the program and re-distribution of members to the remaining plans, by the end of September.
- The Department expects to implement an expedited Fair Hearing process in October.
- DSS has responded to the interrogatories related to the dental litigation.
- Mark Schaefer, Ph.D has joined DSS as the children behavioral health initiative project coordinator and will work with DMHAS on transitional and adult MH issues. Public hearings have been held about the RFI and a DSS/DCF legislative report will be made in October or November.
- The Department will implement a HUSKY presumptive eligibility pilot with 5 SBHC in October.
- DSS is working on the process to enroll parents/caregivers (@150%FPL) of HUSKY A children, to begin January 1, 2001.

Ophthalmology Services for HUSKY Children

Dr. Leonard Banco stated at the July Council meeting that availability of ophthalmology services for HUSKY children in Hartford County has been a problem. Deborah Hine (BCFP) stated that lack of Hartford ophthalmologists to provide service to young children (<4 years of age) has been a problem that pre-dates managed care and is unrelated to the Opticare problem. The Children's Medical Center and BCFP are meeting to resolve the issue. Ms. Hine stated that she is unaware of children not getting care as the MCO authorizes out-of-network services. The resolution of ophthalmology services issue will be reported to the Council.

Behavioral Health Outstanding Receivables

James Gaito (DSS) reported on several mediation initiatives that the department has worked on with the MCOs and behavioral health providers to resolve outstanding claims issues:

- Methadone maintenance programs originally reported several million dollars in unpaid claims. There is now $19,500 remaining in dispute. Letters have gone to the plans involved to pay providers the adjudicated amounts within 45 days.
- Mental health providers reported $1.3M in outstanding claims over several years; a DSS audit determined an amount of $62,000 owed the participating providers. A letter from DSS has been sent to the MCO's regarding payment of these claims. It is expected these issues will be resolved by mid-October.
- There have been recent problems with OP provider payments by PROBH; the Child Guidance Association survey showed outstanding receivables amounting to $800,000 owed providers by PROBH. Mr. Gaito state that in some cases the owed amounts reflects the billed amount rather than the provider/MCO contracted amounts. The vendor reports $123,000 outstanding receivables owed the outpatient providers. Mr. Gaito stated that PHS/PROBH have a process of monitoring the payment issues. The Department assumes PHS/PROBH are working to resolve the balance of the owed amounts to inpatient and outpatient providers.

Council questions reflected the serious concern that the PHS/PROBH financial issues are creating a significant monetary burden to the mental health safety net providers in the HUSKY program:

- Sen. Harp questioned if the escrow account established by PHS to handle the PROBH payment issue is taking care of the solvency issues for PROBH?

  Janice Perkins (PHS) stated that PHS is in litigation with PROBH and the final resolution will depend on the outcome of the litigation. Ms. Perkins stated that everything that can be done is being done to ensure provider payment for services rendered.

- Jeffrey Walter stated that there is a larger payment problem than referred to by DSS earlier. Hospital unpaid claims range in the $5-600,000 amounts. Reports from hospitals are that they are not getting paid nor are they getting answers as to when they will receive payment for services already provided. Mr. Walter stated there is a real possibility that hospitals will terminate their contract with PHS and/or exercise their options in litigation. There is real concern among providers that, if the financial problem

remains unresolved, PROBH or their successor may lack the network capacity to provide inpatient care.

Janice Perkins stated that PHS does not know what message PROBH is giving to providers. Resolution of the financial problems and ensuring continuity of care within the plan is a high priority for PHS. Ms. Perkins was unable to say how the problem will be resolved at this time because of the pending outcome of the litigation.

- Jeffrey Walter and Rep. Nardello stressed the importance of DSS oversight over contractor/vendor contracts. The Department was asked to comment as to whether the new DSS/MCO contract (1999) improved the department's oversight in this area?

  Mr. Parrella stated that the DSS contract is with the main carrier; the Department does not become directly involved with the vendor. Vendor performance is the responsibility of the main carrier. The Department will bring vendor contract/performance issues to the attention of the main carrier with the expectation of resolution of the vendor problem. The MCOs notify DSS of changes in vendors and any contractual changes. In the case of PHS/PROBH, the department plans a conference call with the CEO of the main carrier in the next week.

- Mr. Walter stated that the Behavioral Health subcommittee brought a recommendation to the Council that MCO billing and DSS payment for inpatient reinsurance is done on a monthly basis, which the department reported agreed to do. Has PHS received the reinsurance payments in a timely manner from DSS?

  Janice Perkins stated that PHS has sent in monthly reports to DSS. Ms. Perkins was unsure if the MCO received the July check.

- Senator Harp asked PHS that if providers are not getting paid, whom do they go to for resolution of the payment issues – PHS or PROBH?

  Janice Perkins stated that the providers should work with PROBH first. PHS is distributing funds to PRO to ensure that providers receive reimbursement. PHS is monitoring the payment of claims.

- Mr. Walter asked PHS if the MCO is satisfied that the claims are getting paid and PROBH is up to date with their provider reimbursement?

  Janice Perkins stated that providers are being paid but that PROBH is not as current in payments as PHS would like. Ms. Perkins did not know the detail of the claims payment status to comment further.

  Jeffrey Walter stated the message to the Council, as we move forward, is the need to find mechanisms by which the behavioral health program is adequately funded. The past problems with HealthRight/ValueOptions and this current problem involving PHS/PROBH illustrate the need to review these mechanisms. Mr. Walter suggested that PHS, as they look to a new behavioral health vendor, consider replicating the Administrative Service Organization (ASO) that BlueCare has, rather than continuing with a full risk-based contract, such that the MCO currently has with PROBH.

Senator Harp ended the discussion by stressing the seriousness of this problem (PHS/PROBH payment issues) to DSS, stating that the earlier presentation on the SNP system illustrates that lack of MCO timely payments have the ability to destabilize the tenuous financial stability of the SNP system. The Senator has recommended to her provider constituents that they file a complaint with the Attorney General's office if they cannot obtain resolution of the payments owed them. Mr. Parrella stated the DSS contract with the MCOs does have sanctions associated with untimely provider payments; however this is difficult to monitor within the department. Senator Harp stated that providers must document claims issues clearly and report issues in a timely manner to the department.

Senator Harp stated that in the past the Department has publicly criticized the Council for not addressing specific MCO issues as they related to HRI. The Senator stated that; "Today we are saying that the PHS/PROBH issue is a major problem that threatens the whole behavioral health system. This is a clear message to the department of the Council concerns". Rep. Nardello reiterated the importance of the role of DSS in oversight of health plan/vendor contracts and performance and suggested that as the program moves forward, this oversight role may need to be strengthened.

Subcommittee Reports

- The subcommittee is hosting two forums in October on BH administrative best practices. The Forums seek to improve the program through identifying and establishing best practices in the authorization/claims process and access to wrap around services.
- The Quality Assurance subcommittee reported that the subcommittee is organizing an Asthma HUSKY administrative forum to be held on Nov. 17 at the LOB. Issues will include administrative practices related to existing barriers to care access and improved care coordination and communication among providers, consumers and MCOs. The outpatient behavioral health study, a collaborative effort between the BH and QA subcommittee and among providers, MCOs and consumer representatives has begun August 1, 2000. Provider training sessions will continue through September throughout the State.

Council Quarterly Report
The report was approved and accepted without change.

The October Council meeting is Friday October 27 at 9:30 AM in LOB RM 1D.